Maine Tuberculosis Control Program: LTBI Treatment Referral

Phone: 207-287-8157
Fax: 207-287-3727

Date of Report:_____

Demographics

Last name: _____ **First Name:** _____ **Sex:** ☐ Male ☐ Female

Date of Birth: _____ **If patient <18 years, name of parent:** _____

Address: _____ **Phone:** _____

City: _____ **State:** ____ **Zip:** _____ **Country of birth:** _____

Primary language: _____

Ethnicity: (choose one)
☐Non-Hispanic
☐Hispanic

Race: (check all that apply)
☐White ☐Black/African American
☐Asian ☐Pacific Islander
☐American Indian or Alaska Native

Patient weight: _____ **kg** _____

Does patient have health insurance? ☐No ☐Yes
If yes, name:

Health Information

Reason for Testing:

☐Contact to Active TB Case ☐Foreign Born ☐Substance Abuse

☐Immunocompromised ☐Lives in Congregate Setting ☐Other: _____

☐Diabetic

Screening Test:	☐TST	mm	AST_____ Normal ☐Abnormal ☐ ALT_____ Normal ☐Abnormal ☐
Date:	☐QuantiFERON	☐Pos ☐Neg ☐ Indeterminate	
	☐T-Spot	☐Pos ☐Neg ☐ Indeterminate	

Chest X-Ray: Date: _____ ☐Normal ☐Abnormal - consistent with active TB ☐Abnormal - not active TB

Clinician has ruled out active TB disease?: ☐Yes (i.e. no TB-related symptoms or physical findings)

Treatment Information

Ordering Provider Information

Ordering Provider: _____

Address: _____

_____

Phone: _____

Fax: _____

Public Health Nurse (PHN) Service Request:
All LTBI patients will be referred to PHN unless specified below

☐ I **do NOT** request PHN Services for this patient
If not, reason why: _____

Drug Request

	Dosage (mg)	Order Date
☐Isoniazid: 1 daily for 9 months		
☐Rifampin: 2 daily for 4 months		
☐Isoniazid and Rifapentine: 1 dose weekly for 12 weeks		
☐Pyridoxine (B6)		
☐Other:		

Pharmacy:

_____
Pharmacy Name

_____
Phone #

Office use only:
Date received by TBC_____ Pharmacist Name:_____

Date faxed to PHN CREF_____ Sender_____ Patient ID#:_____